DBT of Southern Oregon
Integrated Health Services, INC
Ph: (541) 621-0303 Fax:541-708-6557

CLIENT INFORMATION

Today's Date: ____________

Client Name____ Date of Birth______________ Age _____

Mailing Address____
Street City Zip
Physical Address____
Street City Zip
Cell Phone_______________________ Leave message? Y__ N__ Work Phone __________________________
Leave message? Y___ N___ Home Phone __________________________ Leave message Y___ N___
Employer ____ Preferred Pronouns: ____________

Who lives in the Home: ____
____

Emergency contact ________________________________ Connection to You ___________________________
Their Cell Phone_____________________________ Home Phone _____________________________________

Are you currently taking any prescribed medications? **Yes** C **No** C

Name Dose How Often Taken For What Reason
____
____
____

Name and phone number of your Primary Care Practitioner: Are they Prescribing above Meds? Y__ N___
____

Check all symptoms that you have experienced in the last two months:

Isolating from others___
Sadness ___ extreme? ___
Trouble concentrating ___
Problems getting along with friends or family ___
Eating more__ Eating Less ___
Extreme mood swings ___
Trouble performing your job ___
Lack of enjoyment of usual activities ___
Low self esteem ___
Thoughts of death ___
Obsessions or compulsions ___
Feelings of anxiety ___ Panic ____
Feeling suicidal ____Past ____

Feeling hopeless___
Feeling tearful ___
Sleeping more ___ Sleeping less ___
Lack of energy ___
Weight gain __ Weight loss ___
Change in sexual interest or function ___
Overspending/buying impulsively ___
Impulsive risky behavior ___
Easily irritated ___
Feeling excessive guilt ___
Feeling more talkative/pressured speech ___
Racing thoughts ___
Cutting self ___

Are you at risk to be harmed by physical violence? Y___ N___
Are you at risk of harming others? Y___ N___

Do you use Alcohol? Y___ N___ How often?____________________ How Much?_______________________
Do you use Drugs? Y___ N___ How often? ______________________How Much? _______________________

Check any of the following that apply to you:

Depression

Job stress/performance issues

Check any of the following that apply to you:

___ Depression
___ Anxiety/Panic Attacks
___ Drug or Alcohol use/abuse
___ Marital/Relationship Issues
___ Physical/Emotional Abuse
___ Sexual Abuse/Harassment
___ Eating/Food Issues
___ Gambling
___ Parent/Child Issues
___ Job stress/performance issues
___ Trauma issues
___ Visual/auditory hallucinations
___ Caretaker for the Elderly/Disabled
___ Medical /Health Issues
___ Porn
___ Grief/Loss Issues
___ Legal Issues
___ Other _____________

Describe any physical problems you have been experiencing during the past 60 days:
____

Have you been in therapy before? Y ___ N___ Counselors Name ______________________________________
Approximate Dates ________________ For what issue?____
Any Psychiatric Hospitalizations? Y ___ N___ Where? ____________________________________
Approximate Dates ________________ For what issue? ____
Alcohol and Drug Treatment: Y ___ N____ Where? _______________________________ Inpatient Y ___ N___
Approximate Dates_______________________________

Are you ***currently*** working with **any** other Therapists or mental health providers such as a psychiatrist? **Yes** C **No** C If **yes**, please provide name(s) and phone number(s).
____

Please describe the problems that brought you here today that you want to address in our work together:
____
____

What are your goals for therapy and how do you hope it will help you? How will you know it is helpful?
____
____

Despite living in ___________________ I am willing to travel to Medford Y___N___ or Ashland Y___N___

I understand that completing these packets does not make me a client of DBT of Sothern Oregon. I understand that JCMH has a free crisis program. I further understand that I do not become a client until I meet face to face with a therapist.

Signature: ____ **Date:** ______________

INSURANCE RELEASE FORM

Client Name: **Date:**

	Insurance Information		For Secondary Insurance
Insurance ID # _______	______________________	Insurance ID #	______________________
Ins Co. Name _____________	______________________	Ins. Co. Name	______________________
Policy Holder's Name________	______________________	Policy Holder's Name	______________________
Relationship to client	______________________	Relationship to client	______________________
Policy Holder's Address______	______________________	Policy Holder's Address	______________________
Group #	______________________	Group #	______________________
Policy Holder's DOB	______________________	Policy Holder's DOB	______________________

Address______	____________________________	Policy Holder's Address	____________________________
Group #	____________________________ ____________________________	Group #	____________________________ ____________________________
Policy Holder's DOB	____________________________	Policy Holder's DOB	____________________________
Male _____ Female _____		Male _____Female _____	
Employer	____________________________	Employer	____________________________

Deductible $_________ Has it been met? Yes c No c Co-payment $_______

Person responsible for deductible and co-payments: ________________________________

Address of responsible party:

____

Street City State Zip

Does your insurance company authorize these visits? Yes c No c

Authorization number _________________________________ Number of visits ____

Referred by:____

Nearest relative or friend I can contact in case of emergency:

____

Name Relationship Phone

IF YOU WOULD LIKE ME TO BILL YOUR INSURANCE COMPANY FOR YOU, PLEASE READ THE FOLLOWING INFORMATION AND SIGN BELOW:

Fees for service are $160.00 per 50 minute session with group rates posted. I understand that I am ultimately responsible for these fees, and agree to pay any balance indicated by my insurance as my responsibility. I further understand and agree that I will be charged $40.00 for a missed session that I do not cancel within 24 hours and $80.00 for any session I do not call to cancel and do not attend. I hereby authorize the release of any personal information necessary to process my insurance claim, including my diagnosis. I understand that may become a permanent part of my insurance records. I authorize payments directly to Integrated Health Services, INC.

RESPONSIBLE PARTY SIGNATURE____

Date

DBT of SOUTHERN OREGON THERAPIST SIGNATURE ____

Date

Client Rights And Responsibilities

Client Name: **Date:**

Confidentiality Everything we discuss in session will be held confidential with the following exceptions:

1. I am required by law to report suspected child or elder abuse
2. I will breach confidentiality if I feel you are in imminent danger of harming yourself or someone else.
3. I may need to make reports to other agencies with your consent.
4. I may need to consult with my supervisor or colleagues about your case (your name will be withheld).
5. The clinical notes which are my property as an in independent contractor are also the property of DBT of Southern Oregon.
6. I may need to present information from your records in court if a claim is filed against me, by you.
7. I will need to release a limited amount of information about you to your insurance company in order to process claims. This may include diagnosis and treatment plan, and this information may become a permanent part of your insurance records.
8. You understand that if this account is submitted to an attorney or collection agency, if we have to litigate in court or your past due status is reported to a credit reporting agency, the fact that you received treatment at my office may become a matter of public record.

Client Rights As a client of an Oregon licensee you have the following rights:

1. To expect that your therapist has met the minimum qualifications of training and experience required by state law.
2. To examine public records maintained by the Oregon State Board of Clinical Social Workers, 3218 Pringle Rd. SE Suite 240, Salem, Oregon 97302 and to have the board confirm your therapist’s credentials.
3. To obtain a copy of the code of ethics.
4. To report complaints to the board.

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3. To obtain a copy of the code of ethics.
4. To report complaints to the board.
5. To be informed of the costs of services prior to receiving services.
6. To be free from discrimination on the basis of race, religion, gender or any other protected category while you are receiving services.
7. To review your records.
8. To not be exploited by your therapist for their own personal benefit or advantage.
9. To be assured privacy and confidentiality with the previously mentioned exceptions.

Client Responsibilities:

1. To keep all scheduled appointments and to contact me at least 24 hours in advance to cancel or reschedule.
2. To attend all sessions alcohol and drug free.
3. To make all your payments completely and on time and notify me of changes to your insurance promptly.
4. To be active in the treatment process.

Permission to treat: I acknowledge that it is my choice to participate in therapy and I realize that the outcome of therapy depends upon my personal investment in the treatment process. If I decide to terminate treatment I will discuss termination before ending treatment.

HIPPA NOTICE : I have been offered a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy guidelines. I have read this and understand how my private health information will be used.

Before you sign below, please ask any questions you may have of this document. Your signature acknowledges agreement and understanding of this contract.

CLIENT SIGNATURE____

Date

DBT of SOUTHERN OREGON THERAPIST SIGNATURE ______________________________________

Date